CIRCULOGENE

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AUTHORIZATION FOR RELEASE OF LABORATORY RESULTS

COMPLETE AND SIGN THIS FORM TO REQUEST RELEASE OF LABORATORY RESULTS

Patient Information:

Patient Name::_____ Accession #:_____

Address: _ _____Date of Birth:_____

Purpose of Release

_____

_____

_____

Laboratory Results To Be Provided To:

Name of Person/Organization/Facility: _____

Send Via:
Mail: ☐ _____
Fax: ☐
Email: ☐

Phone Number: _____Relationship to Patient:_____

- *I understand that the information used or disclosed may be subject to re-disclosure by the Person/Organization/Facility receiving it, and may no longer be protected by federal privacy regulations.*
- *I may revoke this authorization with written notification of my request to revoke to the Compliance/Privacy Officer of CIRCULOGENE via mail: SF51/PO BOX 830525, Birmingham, Alabama 35283-0525 or email: compliance@circulogene.com*

My signature below confirms my voluntarily request and authorize Circulogene to release my laboratory results to the above name Person/Organization/Facility:

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship of Patient

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS

The United States Department of Health and Human Services website contains complete information concerning the Privacy Rule. Specifically, the page which concerns individuals' right to access their health information can be found at http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/.

HIPAA Authorization For Release of Medical Records

CONFIDENTIAL